fraserhealth

# DIABETES AND PREGNANCY CLINIC REFERRAL

PLEASE COMPLETE IN FULL AND PRINT CLEARLY

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**Patient's Full Legal Name:** _____
Last First Middle

**Other Name(s) (if applicable):** _____

**Personal Health Number:** _____ **Date of Birth:** ____/____/____ *(DD, MM, YYYY)*

**Address:** _____ _____
Street City Province Postal Code

**Home Phone:** _____ Cell Phone: _____

*Interpreter Required: ☐ No ☐ Yes Language: _____

Insurance Type: ☐ MSP ☐ WCB ☐ Out-of-Province ☐ Self-Pay Other: _____ RCMP or Armed Forces #: _____

| G T P SA TA L | **Multiple Gestation:** ☐ Yes ☐ No ☐ Twins ☐ Triplets ☐ Other |
|---|---|
| **LMP:** (DD/MM/YY)<br>Circle which is the final EDC<br>**EDC by LMP:** (DD/MM/YY) **EDC by U/S** (DD/MM/YY) | ☐ Gestational Diabetes ☐ Idiopathic Macrosomia<br>☐ Pregnant Type 1 Diabetes ☐ High Risk Diabetes in Pregnancy<br>☐ Pregnant Type 2 Diabetes<br>☐ Preconceptual ☐ Other: _____ |
| Additional Comments: (e.g. if patient is not appropriate for group education, phone patient directly, etc.) | **Diabetes Medications:** ☐ Not applicable<br>☐ Metformin ☐ Other: _____<br>☐ Insulin Type: _____ Dose: _____<br>Type: _____ Dose: _____ |

**IMPORTANT: PLEASE ENSURE THE FOLLOWING ARE ATTACHED** (to avoid delays)

☐ 2 Hr GTT
☐ A1c (within 3 months in T1DM, T2DM)
☐ Antenatal Record Part I and Part II (If started)
☐ All relevant medical reports/labs related to maternal diagnosis, T1DM, T2DM, and/or high obstetric risk

**Family Physician** (if different from referring source)
Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ Patient has no GP/NP

**Referring Health Care Provider**
Name: _____
MSP #: _____
Phone: _____ Fax: _____
☐ GP ☐ Prenatal Clinic ☐ CBP __ NP __ RM
☐ OB/GYN ☐ MFM ☐ Other: _____

**For DAP use only:** ☐ Missing lab work (GTT or A1c) request made on _____ (date)
☐ Interpreter needed _____ 1½ hour for 1:1) ☐ Interpreter Booked
☐ Class & Dr. ☐ Regular (7-1 0 days) ☐ Urgent (within 3 business days) ☐ Punjabi Class
***Do not book 1:1 during class time***
☐ 1:1 Clinician & Doctor (☐ Same day ☐ 1 week later ☐ Urgent)
☐ Preconceptual (☐ Same day ☐ 1 week later)
☐ Pump 1:1 Clinician & Doctor (☐ Preconceptual ☐ Pregnant)

**DAP Appointment:**
☐ Class ☐ 1:1
**Date:** ____/____/____ (DD, MM,YYYY)
**Time:** _____
☐ Follow-Up
**Date:** ____/____/____ (DD, MM, YYYY)
**Time:** _____

Referring Practitioner Signature: _____ Date of Referral: _____

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